# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

**PART I: GENERAL INFORMATION**

| **Type of Requestor:** ( x ) HCP ( ) IE ( ) IC | **Response Timely Filed?** () Yes (x) No |
|---|---|
| Requestor's Name and Address<br>Oxymed, Inc.<br>P O Box 972557<br>Dallas, Texas 75397-2557 | MDR Tracking No.: M4-03-8924-01<br>TWCC No.: ___<br>Injured Employee's Name: ___ |
| Respondent's Name and Address<br>J C Penney Corporation, Inc.<br>Box 19 | Date of Injury: ___<br>Employer's Name: ___<br>Insurance Carrier's No.: 949454601 |

**PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)**

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| **11/18/02** | **11/18/02** | **E0860** | **$122.58** | **$0.00** |
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**PART III: REQUESTOR'S POSITION SUMMARY**

Requestor states in their position statement, "TWCC rule guideline 134.600 clearly states that we are to be reimbursed at the estimated cost, which is the full billed amount."

**PART IV: RESPONDENT'S POSITION SUMMARY**

Carrier's response was untimely. Carrier's EOB denial is "The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

HCPCS code E0860 item should be billed at the usual and customary rate of the DME provider. Carrier shall reimburse at a fair and reasonable rate per the MFG DME IX (C).

Per Commission Rule 133.307(j)(f), the reimbursement for these items would be at a "fair and reasonable" rate.
The requestor did not submit product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicating that their charges were fair and reasonable per rule 133.307(g)(3)(D).
Therefore, based on this information additional reimbursement is not recommended.

**PART VI: DETAIL FINDINGS (If needed)**

| Date of Service | CPT Code | Amount in Dispute | Amount Due | Date of Service | CPT Code | Amount in Dispute | Amount Due |
|---|---|---|---|---|---|---|---|
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| | | | | **Total Left Column:** | | | $0.00 |
| | | | | **Total Amount Due:** | | | $0.00 |

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

**Ordered by:**

| | Michael Bucklin | 12/27/04 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Order |

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____